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## CLINICS.

### CLINICAL LECTURES.

*Clinical Lecture on the Treatment of Wounds.* Delivered at the Queen's Hospital, Birmingham, by **SAMPSON GANGER, F.R.S. Edin., Surgeon to the Hospital.**

**GENTLEMEN:** Wounds of all kinds must, while you are surgeons, be the objects of your care. The one great question for you to solve will be, how least painfully, how the most speedily and most safely, you can assist or promote the natural process of healing.

Teachers, in text-books and hospital wards, differ very widely on the theory and practice of this fundamental part of surgery. I shall not attempt to enu-

rate their differences, much less either to confute or reconcile them. My present aim is to place before you the evidence of typical cases, in the support of what I believe to be the first and essential principles which should govern the practice of the surgeons in treating wounds.

I invite your attention to this little old gentleman, who has kindly attended here this morning for your instruction. He consulted me about two months ago for a cystic tumour, about as large as a hen's egg, in the right temporal region. The skin was very red, tense, and painful, and the hat, though a very soft one, was worn with much difficulty. After transfixing the growth vertically through the base, and peeling out the two halves of

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the cyst, with its bread-sauce-like contents, I dried the interior of the wound with a fine sponge. The edges were then very accurately approximated, and kept so with a few strips of lint soaked in styptic colloid. A few turns of bandage completed the dressing. When I removed it, at the end of five days, there was not a drop of discharge, adhesion was perfect, and afforded a simple but complete illustration of the surgeon's first intention in treating wounds—to secure direct union. All that is visible of the cicatrix is a very fine, pinkish line, extending upwards about two inches from the right ear.

Please to note—firstly, that the wound was thoroughly dried with a fine sponge; secondly, styptic colloid was used to keep the edges in contact; thirdly, the parts were not disturbed until the fifth day, when union was complete and solid.

Drenching wounds with water during an operation, and washing them with it afterwards, are mistakes. Water favours decomposition, which is the enemy of healing action.

The styptic colloid, used to keep the edges of the wound together, is the admirable preparation introduced in 1867 by my friend Dr. B. W. Richardson.<sup>1</sup> In removing the styptic colloid dressing common water should be scrupulously avoided, and a mixture of alcohol and ether employed, or equal parts of absolute alcohol and distilled water, warmed to a little above the heat of the body.

It has been noted that the dressing was not touched for five days after the operation. Once divided parts—be they hard or soft, bones or muscles, skin or nerves

—are adjusted with a view to union, the less they are disturbed the better.

A case illustrating the same principles, though on a somewhat larger scale, is that of C. H—, aged forty-three, who was lately in Ward 5, whose right breast I removed on the 20th May, with a small hard gland from the corresponding axilla. Of the operation it only need be said that, according to my usual practice, I cut down upon the sternal origin of the great pectoral and dissected it clean, so as to make sure of thorough removal of the diseased mass. I am convinced that many so-called rapid recurrences of cancer are only growths of pieces left behind, and that *thoroughness* is the very essence of success in extirpation of malignant growths. After removal of the breast, the edges of the wound were neatly brought together by numerous points of silver suture, and dressed with a layer of fine cotton-wool and over it picked oakum. An evenly compressing bandage was then applied round the chest, and made to include the arm and hand in the flexed position so as to fix them immovably to the side. The first night the temperature rose to 101.3°, but it never rose afterwards above 100°.

The wound was first dressed at the end of the fifth day after the operation. A great part of it being healed by the first intention, a large number of the sutures were removed, and strips of adhesive plaster applied, so as to keep the edges in apposition; a pledget of oakum with a compressing bandage completed the dressing. On June 1st the remaining sutures were removed. The wound was then nearly all healed, and the same dressing applied. On June 8d (fourteenth day after operation) the entry on the card is "Patient dressed (as before), and sent home well."

The points in this case to which I wish to direct your attention are—(a) the numerous sutures; (b) the cotton-wool and picked oakum dressing; (c) the compressing bandage; (d) the rare dressing.

Metallic sutures so very rarely cause any irritation, that they may be inserted very near each other with impunity. Sutures far apart, with gaping intervals,

<sup>1</sup> Styptic colloid, as prepared after the instructions of Dr. Richardson, F.R.S., by Messrs. Robbins & Co., of Oxford Street, is produced by saturating ether entirely with tannin and a colloidal substance, xylodine, or gun cotton, a little tincture of benzoin being finally admixed. (Vide D. B. W. Richardson in *Medical Times and Gazette*, 1867, vol. 1, p. 383 et seq., "On a new Styptic and Adhesive Fluid—Styptic Colloid; and on healing by the First Intention." Also, by the same author, "On the Science and Art of Healing Wounds," in *Transactions of St. Andrew's Medical Graduates' Association* for 1871, London, 1872, p. 37 et seq., and *MEDICAL NEWS*, June, 1867, p. 81.)

are comparatively useless. If the cut surfaces are to adhere, they must be brought into contact and kept there, and for this purpose metallic sutures half an inch apart, or even less, are most efficacious. I often apply intervening strips of lint soaked in styptic colloid, but in this case only placed over the wound a layer of fine cotton-wool, and a pledget of picked oakum. The best cotton-wool for surgical dressings is that sold for jewellers in thin sheets, about eighteen inches by twelve, with alternate layers of tissue-paper. You will often see claims of priority for cotton-wool dressing. I do not pretend to say who first introduced it, but the credit of generalising its application in the treatment of a great variety of surgical injuries chiefly belongs to Burggraave, of Ghent.<sup>1</sup>

It has been recorded that the breast case was only dressed three times, in the fortnight which elapsed between the operation and the patient's discharge, in accordance with the principle of infrequent dressing, of the minimum of disturbance to insure the maximum of rest, dwelt upon in the preceding case, and equally borne out by those to be presently brought to your notice. To the same end the smoothly and lightly compressing bandage round the chest very powerfully contributed. Of all surgical agencies none so beneficent as compression, none requiring more delicate manipulation, none so inadequately appreciated. Under a smooth and uniformly, while lightly compressing bandage, extravasations of blood are absorbed, the healing action is promoted, and a soothing influence is exercised. There must be no constriction—only equable adaptation of surface to surface with the light pressure which always comforts. There must be no squeezing like that of an old college friend's hand when seen after long absence; such pressure as that, if continued, is intolerable constriction. The soothing surgical pressure is like that which you

interchange with the hand of a lady, the pleasure of whose meeting is tempered by the respectful regard which she inspires. Your hand adapts itself to hers, and gently presses it wherever it can touch it, but nowhere squeezes it for fear of offending. Such pressure as that, when employed by the surgeon in the treatment of injuries, always soothes and heals.

To apply a nicely compressing bandage well, you must practise hundreds and hundreds of times, bearing in mind that in surgical, as in all art, the greatest results are often obtainable from the simplest means, provided they be employed with the skill which can only result from the most patient assiduity.

These principles are illustrated by the two patients who have undergone amputations, and who are now before you.

I amputated the middle finger of this man's right hand in the course of my clinical lecture last week. As the result of old injury, the finger was bent and stiff, so as to be in the way. I therefore removed it at the metacarpophalangeal articulation, being careful not to wound the palm, and including in the elliptical incision so much of the covering of the phalanx as to admit of easy closure of the wound over the big knuckle. The edges were united by three points of silver suture, a fine drainage-tube placed in the lower angle of the wound, which was covered with a pledget of picked oakum; a moist pasteboard splint was now bandaged to the palmar aspect of the limb from the tips of the fingers to the elbow, and the forearm suspended in a sling.

This other patient, aged sixteen, was admitted to Ward 3, the 18th May ult., with his forearm crushed by machinery to within two inches of the elbow. As the bones were not split into the joint, I amputated just below it, utilizing some of the least damaged skin to cover it. Where the skin was quite sound the edges were brought together with two points of suture, elsewhere the parts were approximated with strips of lint soaked in styptic colloid, a drainage-tube being left in the lower part of the wound. The stump was covered with a layer of cotton-wool and oakum, and rectangular

<sup>1</sup> *Chirurgie Simplifiée. Nouveau Système de Pansements Inamovibles. Par le Dr. Burggraave (avec plaques).* Bruxelles, 1853. Also, by the same author, *Le Génie de la Chirurgie.* Gand, 1853, p. 25 et seq.

pasteboard splints were applied with gentle pressure to insure perfect immobility and prevent swelling. When the apparatus was opened four days afterwards, there was very slight sloughing of the margin of one flap, but the stump was of good colour and healthy temperature, without tension. The same dry dressing with pressure was applied, and the lad was discharged on the 17th of June, a month within a day from his admission, the stump then quite healed, having been dressed altogether seven times after the amputation.

A parallel case is that of James B—, aged six, discharged the other day from Ward 6. The soft parts of his left lower limb had been extensively crushed by a wagon, and an attempt had been made to save the limb. Sloughing and profuse suppuration had been followed by such exhaustion that the lad might fairly be said to be moribund when I amputated the thigh in the upper third on the 22d of April. I dressed with cotton-wool, oakum, pasteboard splints, and nicely compressing bandages, and the lad was discharged with a sound stump and in good health on the 15th of June. In the forty-seven days which elapsed from the operation to his leaving the hospital the dressing was only renewed six times.

Not to go over the ground already trodden in commenting on the other cases, I shall only remark on the splints and the drainage-tubes employed in these amputations.

Coaptation of divided surfaces once effected, absolute rest is the first essential to the healing process. That rest is best secured, in the case of amputations, by moulding to the stump well-softened pasteboard splints, and fixing them with evenly compressing bandages. As in the case of fractures, the joint above the injury should be included in the splints, and great contributory benefit may be derived from the nice adaptation of sand-bags.

Of Chassaignac's drainage-tubes in the treatment of wounds it is impossible to speak too highly; but useful as they are after amputations, removal of tumours, and such-like operations, it is in such

cases as this breast that their advantages are perhaps most conspicuous.

When this woman was before you last week, her pale, drawn face betokened suffering and exhaustion; the big, pendulous, and exquisitely tender left breast discharged matter through half a dozen openings, the result of post-partum mammary abscesses and linseed poultices. I passed a long probe from the lower aperture on the outer side, under the mammary gland, obliquely upwards and inwards, out at the uppermost aperture near the sternum. A ligature secured to the eye of the probe enabled me to carry a good-sized drainage-tube along its track, and I left it there with both ends depending, covering the breast with a good pledget of dry oakum, and suspending and compressing it with an evenly compressing bandage. The poor woman was easy at once, her appetite improved, and she slept well. When the dressing was removed, after a lapse of four days, the breast was soft and much diminished in size; the openings other than those traversed by the drainage-tube were healing rapidly, and the woman is now cheerful and rapidly convalescent.

Here is an equally successful case of a different kind, yet illustrating substantially the same general principles which should guide you in the treatment of all wounds. This youth is the son of one of our principal ivory and bone turners, who, while practising the other day with a fine circular saw, nearly cut off the soft pad at the end of the right thumb. He did not consult me until the third day, when the flap was swollen, and the wound dirty, the whole thumb throbbing and being very painful. On compressing the radial joint above the wrist, the throbbing and pain ceased, and I taught my patient how to obtain the relief by effecting the compression himself with the left thumb. I then brought the edges of the wound together with narrow strips of emplastrum elemi, leaving slight intervals for the escape of matter, covered the end of the thumb with a little fine-picked oakum, bandaged it so as to effect gentle uniform compression, and supported the hand at an acute angle with the arm, by means

of a sling supporting the forearm and enclosing the elbow, as every sling, to be efficient, should do. Relief was immediate; the dressing was not touched for four days, and only twice afterwards, at intervals of three days. You see the thumb very nearly a match for its fellow, and a linear cicatrix is all that is left of the ugly wound.

This case illustrates, like the previous ones, the advantages of direct compression, with dry and rare dressings, in the treatment of wounds, and it further exemplifies the benefits to be derived from digital compression in the treatment of inflammation of the limbs.<sup>1</sup>

In proof of the statement that the same principles of treatment are applicable, whether the wounded parts be soft or hard, skin, bones, or muscles, or all combined, you have two very striking cases. This carter was brought into the accident ward with the scalp torn from the greater part of the right side of the head, and with two compound and depressed fractures in the parietal and frontal bones respectively. The large flap was cleansed, replaced, and united by eight points of suture, picked oakum and light bandage applied, and an ice-bag over all. The greater part of the wound united by the first intention. The cicatrix is now quite solid, and the man is doing his usual laborious work without ache or pain.

The last case which I shall now bring before you is that of a porter on the Midland Railway, who was brought to the hospital, a distance of fourteen miles, with the left femur literally smashed just above the knee-joint, a fully-laden coal-truck having gone over the limb. The soft parts were extensively torn, but both tibials pulsed, and I felt justified in the attempt to save the limb. Reduction effected and the edges of the wound approximated, a large drainage-tube was passed into it, and a pledget of lint, soaked in styptic colloid, placed over it.

The limb was now accurately encased in a pasteboard apparatus from the crest of the ilium to the toes. The apparatus was not opened for ten days, and once a week afterwards. The man barely limps in walking, and is now doing duty as a signal-man at Selby-cut. One and all these cases illustrate my favourite maxim, that REST, POSITION, and PRESSURE are the trinity of healing surgical graces.—*Lancet*, Dec. 23, 1876.

#### HOSPITAL NOTES AND GLEANINGS.

*Large Retro-uterine Hematocoele; Incision; Recovery.*—A married woman, aged twenty-four, was admitted into the Queen's Hospital, Birmingham, under the care of Mr. JOHN CLAY, on August 29, 1876. She had three children, the youngest of which was twenty months old and was suckled until a month before admission. Her labours had always been good and without complications. Menstruation occurred at the end of a month after the last confinement, and appeared regularly afterwards. During her last menstrual period, about a month since, while engaged in washing the yard, she was suddenly attacked with a violent pain in the back, and in the hypogastric and right iliac regions, where the pain was most acute. She had frequent attacks of pain after this of a spasmodic character which were generally more severe during the night, and were accompanied with distressing dysuria. There was a free menstrual discharge during the whole of the month previous to admission. A fortnight before she had rigors, accompanied with nausea and vomiting, and was compelled to take to her bed. She then discovered a painful swelling on the right iliac region. This, according to her belief, gradually increased in size.

On admission she was anæmic and emaciated; the recumbent posture only possible; legs not drawn up. Abdomen tender on pressure. Pains in the regions previously mentioned. In the right iliac region there was a firm swelling of the size of a large orange. The upper border of this swelling was irregular, and could be traced in an oblique direction, running

<sup>1</sup> Observations on the Treatment of Inflammation by Digital Compression, by Dr. Tito Vanzetti. On Treatment of Fractures of the Limbs, by Sampson Gamgee; London, Churchill, 1871; p. 168 et seq.



from the right iliac crest to the middle of the left groin. Below this line the abdomen was dull on percussion, and the swelling was nodulated, and the boundary-line of the latter was about an inch and a half from the umbilicus. There was a free vaginal discharge of a dark rusty colour. Per vaginam a hard rounded mass was felt completely filling Douglas's space, and pushing the uterus downwards and forwards, simulating in feel and size a gravid uterus of the fourth month in a retroverted condition. The sound was introduced into the uterus without difficulty. The uterus measured three inches, and was in its normal position. Per rectum the mass could be distinctly felt, and the bowel was pushed down in folds. Tenesmus and dysuria very distressing. Pulse 100; temperature 101°. Salines and opiates ordered.

*Sept. 5.* There is an increase in the size of the swelling, and it feels firmer. The upper border is now felt to be on a level with the umbilicus. Abdomen tender on pressure. Pulse 98; temperature 101.4°. Quinine mixture prescribed; opiates continued.

*9th.* The abdomen is extremely tender and tympanitic. Peritonitis is obvious. The aspirator was used to the vaginal swelling, but only a little thick blood followed. Pulse 140; temperature 102.6°.

*10th.* Abdominal pain and tenderness increased. Knees drawn up; countenance anxious. Pulse 140; temperature 102°. Consultation convened, at which Drs. Heslop and Mackay and Mr. Clay attended, in reference firstly to the probability of the extravasation being due to tubal foetation; and, secondly, as to the advisability of evacuating the extravasated blood per vaginam by a free incision into the tumour. The first question, after mature consideration, was not considered very probable, and it was deemed advisable to defer the latter.

*11th.* 10 A. M.: Patient states that she feels better. Abdomen, however, more tympanitic; no sickness. Pulse 132; temperature 103°. To take of acetate of morphia a quarter of a grain every four hours. Compresses wrung out in iced-water to be applied to the abdomen. Is

decided to have a consultation in the evening. 7.30 P. M.: Patient much worse in every respect, vomiting and hiccough; abdomen enormously distended. Pulse 142; temperature 103°. It was determined to incise the tumour without further delay. Mr. Clay, with a guarded bistoury, made an incision of about one inch and three-quarters in length into the centre of the vaginal swelling. The finger was passed through this opening, and the clot broken up by this means; about two pounds of hard offensive clot and coloured liquid were removed. The cavity was carefully syringed with diluted Cond's fluid. The same quantity of morphia was prescribed with a small quantity of brandy every two hours. After the incision and syringing the boundary line of the solid mass was felt to be about two inches nearer the pubis.

*12th.* Patient has had two severe attacks of abdominal pain. After the operation a discharge of bright red blood continued to escape from the vagina, probably from a vessel in the incision, which was arrested by a plug introduced by Mr. Allen at 3 A. M. Urine and flatus passed in large quantity during the night. Tampon removed and cavity syringed out with diluted Cond's fluid. Temperature 103°; pulse 136. Morphia continued. Insufflation of the cavity ordered every three hours with salicylic acid.

*13th.* Bowels moved three times during the night; abdomen very much diminished in size. Pulse 120; temperature 102°.

On the 14th a large quantity of dark offensive clots were removed by syringing the cavity with Cond's fluid, from which she felt much relief. The pulse and temperature daily declined until they became normal. No trace of foetal development was discovered, although careful examination was daily made of the debris brought away by syringing. Salicylic acid was administered for several days in ten-grain doses with the best results. Quinine was afterwards substituted. By the end of the month she was quite convalescent, all traces of the abdominal hardness having disappeared, and the incision quite healed. She remained, however, anæmic, but with the use of tonic

medicines and a generous diet she made a most rapid and permanent recovery. Menstruation had not occurred when she left the hospital for the Convalescent Institution.

In commenting on this case, Mr. Clay remarked that it was one of unusual interest, not alone for the special clinical features it presented, but as illustrating the mode of treatment to be adopted where large extravasations of blood into the cavity of the abdomen had taken place. Of late years the current of opinion has gone somewhat in the direction of leaving these large sanguineous extravasations to become removed by absorption aided by therapeutical measures. There are, of course, those who advocate surgical interference, and the favourable result of this case lends a powerful support to the adoption of this method of treatment in certain cases. There can scarcely be a doubt that in the progress of this case fresh extravasations occurred, which materially increased the size of the tumour. It might have been thought that the temporary increase of size was due to a distended bladder, but it is scarcely necessary to observe that this source of error was carefully guarded against. The opening of the tumour at too early a period of its development would probably have been a fatal mistake. The prudence of the delay sanctioned by the gentlemen engaged in the consultation in the first instance was shown by the fact that the peritonitis set up had completely encapsulated the clot, and thereby facilitated dealing with it after the tumour had been incised. There was no softening of the clot. The fragments which came away were firm, offensive, and dark-coloured, and to have delayed the incision would have insured the death of the patient. Another fact of importance is that the convalescence is considerably shortened. The employment of salicylic acid as a local antiseptic was only partially successful, in consequence of the large amount of blood to be acted upon, but its internal administration was marked with the best effects. The rapid diminution of temperature, pulse, and meteorism in the first twenty-four hours after the in-

cision are worthy of prominent notice. The lesson which this and other similar cases had taught him was not to expect large extravasations to be removed by absorption. That such cases should not be interfered with surgically at too early a period is a safe proceeding, but that they should be watched, and, whether softening takes place or not, if the temperature and the pulse show extensive abdominal complications to be taking place, then at once to make an opening for the coagulated blood. The tolerance of such large continued doses of morphia is also worthy of note. The position and feel of the tumour on the right side of the abdomen lent a powerful impulse to the belief at one time that the origin of the extravasation was due to a rupture of a tubal pregnancy, but no traces of a foetal development could be found. There was besides no history of shock, which generally occurs in such case, and this fact, together with the absence of certain uterine symptoms, was rightly held to negative the supposition.—*Lancet*, Dec. 2, 1876.

*Rheumatic Fever treated by Salicylic Acid; Symptoms of Poisoning produced by the Acid.*—The following two cases of rheumatic fever treated at the Radcliffe Infirmary, Oxford, with full doses of salicylic acid, are interesting, as showing a peculiar train of nervous symptoms which seem to have followed, and been caused directly by, the administration of the medicine. In both, the immediate effect of the acid on the rheumatic symptoms was remarkable—a rapid falling of the temperature and pulse-frequency, a speedy subsidence of pain and swelling of the joints, a cleaning of the foul tongue, and arrest of the sweating being observed. But in both alike, together with the satisfactory abatement of these symptoms, there came on a set of other symptoms, which may thus be summarized: Humming and buzzing in the ears, with gradually increasing deafness; a peculiarly loud, deep, and sighing respiration; a strange restlessness, gradually increasing to delirium, not unlike that of delirium tremens, with involuntary evacuation of urine and feces in the worst of

the two cases; a slow and labouring pulse; an olive-green colour of the urine. All these symptoms declared themselves at the same time that a low temperature, a slow pulse, and an absence of all rheumatic appearances, showed that the disease itself was in abeyance. No sooner was the medicine withheld than the strange symptoms ceased, and the rheumatism returned. In the case related at length, the nervous symptoms were so alarming that Dr. TUCKWELL was afraid to return to the acid in treating the relapses, but blistered the joints after Dr. Herman Davies' plan, a treatment which he had followed out for several years. To compare the blistering with the salicylic acid, both alike seem to act quickly on the painful swellings of the joints; but, whereas the former does nothing more than this, and the rheumatic state continues its course unchecked, the latter seems to have the additional power of controlling the rheumatism itself, of lowering and keeping down the temperature and pulse, and relieving the sweating. At the same time, when given in doses large enough to effect this, the acid may develop certain unpleasant symptoms of its own, which in one of the cases to be related were rather alarming.

Case 1.—H. L., aged eighteen, was admitted 29th Sept. 1876. He had had rheumatic fever when a child, but had continued in good health and at work till seven days ago, when he shivered, and was attacked with pain in the back and with painful swelling of the knees. On admission he was profusely sweating, with rheumatic odour. Both knees, both ankles and wrists, were acutely inflamed, swollen, red, and very painful; tongue thickly coated. Morning temperature 100.6°; pulse 108. Evening temperature, 101.6°. A blowing systolic murmur was heard at the apex, and a shorter systolic murmur at the base of the heart. Ordered to be bedded in blankets, to have no application of any kind to the swollen joints; milk diet; and to have a scruple of salicylic acid dissolved in three drachms of the solution of citrate

of ammonia every three hours, through the day and night.

Sept. 21. The pain had begun to yield at midnight, after four doses of the mixture. All pain and swelling of the joints were gone, and there remained only a little stiffness in the left knee; tongue cleaning. Morning temperature 101°; evening 101.6°; pulse 92. He complained much of thirst, and of buzzing in the ears, as if a hive of bees were over his head. The respirations were regular and slow, sixteen in the minute, but peculiarly deep-drawn and sighing, so that he could be heard breathing at some distance from the bed. Ordered to continue the mixture every three hours.

22d. All rheumatic pain, swelling, and stiffness were gone, and the sweating was much less; tongue clean. Morning temperature 100°; evening 100°; pulse 84. The loud breathing was even more marked. He had passed a very restless night, and was restless at the visit, complaining of the buzzing and of feeling light-headed. Heart-sounds unchanged. Urine of a marked olive-green tint; acid; no albumen. To continue the mixture every four hours.

23d. He was quite free from all rheumatic symptoms, but the same noisy breathing and restlessness continued. A patch of herpes had appeared on the lip. Morning temperature 99°; evening 99.6°; pulse 92. Urine olive-green; the colour not changing on the addition of nitric acid; no albumen.

24th. The same nervous symptoms, with the addition of marked deafness, were present. Morning temperature 97.6°; evening 97.8°; pulse 84. To continue half doses of the mixture, ten grains of the acid, every four hours.

25th. The breathing was so loud that it could be heard at the other end of the ward. He had passed a sleepless night. Morning temperature 98°, evening 99°; pulse 76. Heart-sounds unchanged. To continue ten grains every six hours.

26th. He had been sleepless and deli-

<sup>1</sup> On the solubility of salicylic acid in a solution of ammonium citrate, see the Pharmaceutical Journal of July 15th, 1876.



rious throughout the night, trying to get out of bed. He answered questions properly, but then rambled off to some other subject. Breathing the same. Morning temperature 99.4°, evening 99.2°; pulse 62. To take 10 grains three times a day.

27th. He passed a very delirious night, and had the manner of a person with delirium tremens. He had passed his feces and urine unconsciously. Breathing the same. No rheumatic symptoms. Morning temperature 99°, evening 100°; pulse 70, labouring. Urine olive-green, no albumen. To stop the medicine, and continue milk diet.

28th. He had continued in the same state till three o'clock this morning, when he fell asleep, and was still sleeping heavily at the time of the visit. Morning temperature 99.2°, evening 99.8°.

29th. He had slept the greater part of yesterday and all through the night, and awoke this morning quite quiet and sensible. His evacuations have since then been passed naturally. His breathing was quiet and natural. Morning temperature 99.4°, evening 99.8°; pulse 52, very labouring, and a little irregular. He was very prostrate, and could only speak in a whisper. Heart-sounds unchanged. Urine very faintly green in colour, neutral, no albumen.

30th. He was quiet and rational, and breathing naturally, but all the old rheumatic symptoms had returned. He was sweating profusely. The right knee, ankle, and left wrist were swollen and painful. Morning temperature 100°, evening 102.2°. Joints to be blistered. Effervescing citrate of potash mixture to be taken every six hours.

Oct. 1. The joints were much relieved by the blisters. No nervous symptoms. Morning temperature 100.6°, evening 101.2°; pulse 60. Urine natural in colour, 1028, no albumen. Heart-sounds unchanged.

3d. Another relapse of rheumatic pain and swelling in the left knee and left ankle, with profuse sweating. No nervous symptoms. Morning temperature 102.4°, evening 103°; pulse 72. Joints to be blistered.

From this time there was a gradual fall

in the temperature and return to convalescence, no fresh nervous symptom of any kind having appeared from the time that the salicylic acid was discontinued, although the temperature rose higher and the affection of the joints was severer in the relapses than in the original outbreak.

In Case 2—that of a man aged twenty—the order of treatment was reversed, blisters being first applied, and afterwards, as the fever did not yield, salicylic acid being given in doses of a scruple every three hours. In twenty-four hours from the time that the first dose was taken, all pain and swelling were gone, the temperature and pulse had fallen, and the tongue was cleaning; but there followed just the same nervous symptoms as in the former case—deafness and buzzing in the ears, deep-drawn noisy breathing, restlessness, and at last delirium, with wakefulness and a desire to get out of bed. All these symptoms, which were not so severe as in the former case, ceased quickly when the acid was withdrawn, and did not return, although there were two slight relapses of the rheumatic fever, which were treated with the perchloride of iron.—*Lancet*, Nov. 11, 1876.

## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Treatment of Fractures at the Pennsylvania Hospital.*—Dr. JOHN B. ROBERTS, Resident Surgeon at the Hospital, gives (*Archives of Clinical Surgery*, Dec. 1876) the following account of the method of treating fractures employed at this institution:—

Fractures of the lower end of the radius, whether Colles', above the articulation, or Barton's, extending into the joint, are almost invariably adjusted by forcible extension, and then placed in a Bond's splint, with appropriate compresses to correct deformity. Bond's splint, as you know, consists of a box-like splint, in which the pronated forearm is laid, while the hand is deflected to the ulnar side, and the palm closed over a cylindrical block at the end. By this means the ten-

dency to dragging up of the lower fragment is overcome, and the fingers are allowed considerable motion during the progress of the treatment.

When the humerus is broken, through or just above the condyles, an anterior right-angled splint is generally employed, but when the fracture is situated in the shaft, an internal angular splint, with possibly an external pasteboard one, is applied. If the seat of fracture, however, is near the anatomical neck, it is usual to use the thorax as a splint, and merely bind the arm firmly against the chest; should the upper fragment tend to fall into the axilla, it is kept in proper position by a pad placed in that locality.

The treatment that seems to give best results in fracture of the clavicle is the horizontal position in bed, with the head thrown a little forward to relax the sternomastoid muscle. When this line of treatment cannot be followed, the injury is dressed with a roller-bandage or adhesive strips, so arranged as to meet the indications.

Taking up fractures of the lower extremity, I speak of fracture of the fibula. This comparatively unimportant injury is placed in a fracture-box until swelling subsides, and then a fixed dressing of silicate of soda, or glue and oxide of zinc is adjusted to the limb.

Fractures of the tibia, or tibia and fibula, are placed immediately in the old-fashioned fracture-box with foot-board and hinged sides, which, in many instances, is then suspended, in order that the patient may move about in bed without disarranging the broken bones. Compound fractures, with abundant discharge, are kept covered with bran. In two such cases, recently admitted, there was so much overlapping and displacement of the fragments that Dr. Morton resected the ends, and, in one case, wired the bones together.

Although the fracture-box is generally employed, its use is not absolute. If the bones be broken at the ankle-joint, with lateral displacement, Dupuytren's splint and pad for fracture of the fibula are used. In a recent instance, where the line of fracture split off the external portion of

the tibia, without involving the internal malleolus, and the fibula also was broken, there was great displacement backwards and outwards, which necessitated tenotomy of the tendon of Achilles and the application of Dupuytren's splint on the inner side of the leg.

Fracture of the patella has usually been treated by flexing the whole limb on the pelvis, and drawing down the upper fragment by adhesive strips and bandages. Recently, however, Dr. Morton has tried Malgaigne's hooks without producing any inflammatory trouble, and has obtained far more perfect apposition under their application.

Many cases of fracture of the femur are admitted, and are treated generally by extension, though one of the surgeons prefers Smith's anterior wire splint. The extension apparatus is applied by means of longitudinal and transverse strips of adhesive plaster, to which is attached an iron crib, or framework, containing any number of one pound weights. In some cases, instead of the plaster, a more expensive arrangement of leather straps and buckles is applied in a similar manner, and the weights attached to the foot-piece. The injured limb is then steadied by sandbags or Levis's weighted splints, which consist of long narrow boxes, containing a row of bricks. Fractures through the neck of the femur, owing to the difficulty of making an absolute diagnosis of extra or intra-capsular lesion, are treated by extension for several weeks, until it is determined whether or not union is about to occur. In a case treated not long ago, the diagnosis of intra-capsular fracture was proved, not only by the treatment, but by the post-mortem examination made two or three months after the receipt of injury. There was not the least attempt at union, and the end of the head had been partially absorbed. The anterior wire splint is used by Dr. Hewson for fractures of the thigh, and sometimes of the leg, and, while controlling the proximal joints, gives the patient greater freedom of motion during treatment.

In regard to shortening after fracture of the femur, it may be said that but little importance is attached to the amount, and

measuring is rather at a discount. By a series of measurements of normal limbs, made by Dr. W. C. Cox a few years ago, it was found that there was a considerable difference in many cases where no injury had ever occurred. In fifty-four cases accurately measured only six showed the same length in both limbs, while fifteen cases showed a difference of a half inch or more between the two legs. The smallest amount of variation was one-eighth of an inch, while the greatest reached seven-eighths of an inch (*American Journal of the Medical Sciences*, April, 1875). As this has been well established, it seems useless to become agitated over shortening of one-sixteenth of an inch after fracture of the femur, which, by the way, may make the limbs more uniform than they were previous to the occurrence of the fracture.

The plaster of Paris dressing is seldom used except in cases of delirium tremens, when a rapid setting and solidifying is required to keep the bones steady, and preclude the possibility of the injury being made compound. Solution of silicate of soda is always ready, is so clean, and is applied with such facility that it is generally preferred, notwithstanding the fact that it takes several hours to become firm. The glue and oxide of zinc dressing of Dr. Levis is employed quite frequently also, the latter ingredient being added in the proportion of one part to eight or ten of glue, in order to increase the rapidity of hardening. None of these forms of fixed dressing, however, are applied immediately, as done in New York, but the patient is confined to bed for a series of days until pain and tumefaction have subsided, and often until considerable union has occurred.

*The Caustics of Zinc.*—Several physicians have consulted Dr. SQUIBB as to the best and safest manner of applying the chloride of zinc. The difficulty appears to be that the caustic cannot easily be limited to the part to which it is desirable to apply it; especially is this the case in respect of the application within cavities; for example, epithelioma of the cervix of the uterus, in which disease the chloride

of zinc offers its best results. The excess of caustic gradually creeps down, comes in contact with, and plays the mischief with the vaginal walls; this takes place under the ordinary form of application by means of a pledget of lint, wet with a strong solution of the zinc, which is held in place against the diseased cervix by a tampon.

Dr. Squibb suggests, in the first place, that a less quantity of the caustic be employed, so that by its combining with the albumen of the diseased tissues, there shall be none to overflow upon sound tissues. Moreover, the upper layer of the tampon may be prepared with a carbonate of soda solution and allowed to dry before the application; the soda and excess of the caustic coming in contact, will re-combine and form a chlorinate, a sort of disinfectant. But the soda itself is an irritant, although not a caustic. It may be well to try carbonate of lime: dust the surface of the tampon, and thus disarm the zinc.

But, perhaps, better than these will be the use of the nitrate of zinc. It is less deliquescent, and very much more manageable than the chloride. Dr. Fisher has found it especially applicable within cavities. A hot, concentrated solution is made of the nitrate; into this a layer of cotton is dipped and then allowed to dry; the salt crystallizes in the meshes of the cotton, which can be adapted readily to the contour and irregularities of surface of epithelial growths and the like. This may be held in place by a tampon, which will absorb all excess of caustic.—*Proceedings of Medical Society of County of Kings*, N. Y., Jan. 1877.

*Deaths from Chloroform.*—A case of this occurred at Rahway, New Jersey, on the 5th of January. A lad, aged 14, inhaled chloroform from a napkin prior to the extraction of a tooth. Immediately after the tooth was extracted there was a gasp for breath, a deep sigh, and the head of the boy rolled on one side and he was dead.

At a late meeting of the Obstetrical Society of Boston (*Boston Med. and Surgical Journal*, Jan. 11, 1876), Dr. COTTING remarked that since he came to the

meeting an account of a case of death from chloroform during delivery had been shown him in the last number of the London *Lancet*, and stated that he had himself had, a number of years ago, a case in which death was probably due to the same agent. The patient was a primipara, aged twenty-two. The labour was going on well, and the head was apparently on the point of emerging, when the patient had a slight convulsion. Chloroform was administered, and, the pains returning after a while, the administration was repeated. The head was got away, and the uterus was contracting well, when a tremor occurred and the pulse ceased. The patient was dead. At the time of this occurrence there appeared to be no obvious cause of death; since then, as chloroform has been found to be frequently fatal, Dr. Cotting has been more and more of the opinion that death in this case resulted from the use of this anæsthetic.

*Scarlet Fever in Boston.*—From an official circular of the Boston Board of Health, dated Jan. 9, 1877, we learn that scarlet fever is now prevalent in that city. The board gives notice that every physician must hereafter report to the Board of Health cases of scarlet fever which he may be called upon to attend, and every householder must also give a similar notice of the appearance of scarlet fever within his family. An additional order of the board prohibits any child from any family in which scarlet fever may appear from attending school until four weeks have elapsed since the beginning of the last case of such sickness.

*The Medical Society of the District of Columbia.*—At the annual meeting held Jan. 1, 1877, the following officers for the ensuing year were elected: Dr. S. C. Busey, president; Drs. Garnett and King, Vice-Presidents; Dr. L. Magruder, Corresponding Secretary; Dr. Klienschmidt, Recording Secretary; Dr. Franzoni, Treasurer; Dr. Patze, Librarian; Drs. Murphy, Smith, D. R. Hagner, C. E. Hagner, and Triplett, Board of Examiners; Drs.

Elliot, Antisel, and Morgan, Board of Censors.

*University of Pennsylvania.*—Dr. J. T. ROTHROCK has been elected to the chair of Botany in the Auxiliary Faculty of Medicine, vice Dr. H. C. Wood, who was recently elected to fill the chair of *Materia Medica*, made vacant by the resignation of Prof. Carson.

The Professorship of Hygiene in the same faculty, has recently been vacated by the resignation of Dr. HENRY HARTSHORNE, in consequence of removal to Union Springs, New York.

*Changes in Medical Journalism.*—With the beginning of the new year, we have to chronicle the establishment of two medical journals, as well as the demise of another.

*Toledo Medical and Surgical Journal.*—The initial number of this journal was issued on the first of January, under the editorship and proprietorship of JONATHAN PRIEST, M.D., of Toledo. It is intended to be a monthly periodical of thirty-two octavo pages, containing original communications, reports of societies, correspondence, and editorials. Its publication has been undertaken, the editor informs his readers, in the belief that the profession is not so supplied as to hinder the success of another journal. We trust that Dr. Priest's journal may develop the merit which always insures success.

*The Quarterly Journal of Inebriety*, the first number of which appeared on the first of December last, appears as the official organ of the American Association for the Care of Inebriates, and is offered as the exponent of its principles. The journal will contain the transactions of the Association, with various other contributions from specialists in this field. It is under the supervision and editorial control of the publication committee, of which Dr. T. D. CROTHERS, of the Binghamton Asylum, is Secretary.

*The Clinic.*—With the commencement of its twelfth volume our sprightly contemporary passes under the editorial control of Dr. ROBERTS BARTHOLOW, whose

reputation foreshadows the ability with which its columns will be managed.

The first number appears in a new and improved dress, and the journal will be published as heretofore at Cincinnati on every Saturday.

*Peninsular Journal of Medicine.*—With the December issue this journal closed its career. The Journal, we are informed, has consolidated with the *Detroit Review of Medicine and Pharmacy*, which will be henceforth published under the name of the "Detroit Medical Journal."

**OBITUARY RECORD.**—Died in Philadelphia, on the 30th day of December last, aged sixty-eight years, JOSEPH CARSON, M.D., Emeritus Professor of Materia Medica and Pharmacy in the University of Pennsylvania.

During his long and distinguished career in the profession, Dr. Carson occupied many positions of honor and trust. He was for some years Professor of Materia Medica in the Philadelphia College of Pharmacy, and for subsequently twenty-six years Professor of Materia Medica and Pharmacy in the University of Pennsylvania. Among his contributions to medical literature in addition to numerous fugitive lectures may be mentioned his *Illustrations of Medical Botany*, published in 1847, his edition of Pereira's *Materia Medica*, and the *History of the Medical Department of the University of Pennsylvania*. At a later day we hope to present to our readers an appreciative biographical sketch of Dr. Carson.

At a meeting of the Medical Faculty of the University of Pennsylvania, held January 1, 1877, in relation to the death of Emeritus Professor Joseph Carson, M.D., the following minute was unanimously adopted:—

The Medical Faculty have heard with profound sadness of the death of their late colleague, Dr. Joseph Carson, who for twenty-six years occupied the Chair of Materia Medica and Pharmacy with a distinction and authority to which a lifelong devotion to these branches of science entitled him. His complete mastery of his subject enabled him to give to each part of it in his lectures a due

weight and proportion, and to impress his class with the soundness of his instruction.

Throughout his whole career he was beloved by the students for his kind and gentle manner, and the wise and affectionate interest he displayed toward all who sought his counsel, and especially to his private pupils, who, in after life, delighted to renew their acquaintance with their former teacher and friend.

In the medical faculty he was not less beloved for his simple, cordial, and sincere manners and his perfect truthfulness and directness of purpose, than he was respected for his loyalty to the school whose history, traditions, and capabilities he was best acquainted with, and for his desire to reconcile the exigencies of its position with its duties to medical teaching and to the medical profession.

His former colleagues can never forget their meetings, which were rendered cheerful by his social qualities and satisfactory by the wise discretion of his counsel.

*Resolved*, That the Faculty will attend in body the funeral of Dr. Carson on the 2d instant.

*Resolved*, That the Faculty tender their warmest sympathy to Dr. Carson's family in their bereavement, and that a copy of these proceedings be sent to them, and one also to the Board of Trustees of the University of Pennsylvania.

#### FOREIGN INTELLIGENCE.

*Treatment of Scarlet Fever with Sulphur.*

—Mr. HENRY PIGEON, of Clifton, England, writes to the *Lancet* (Nov. 25, 1876) that "the marvellous success which has attended my treatment of scarlet fever by sulphur induces me to let my medical brethren know of my plan, so that they may be able to apply the same remedy without delay. All the cases in which I used it were very well marked, and the epidermis on the arms in each case came away like the skin of a snake. The following was the exact treatment followed in each case: Thoroughly anoint the pa-



tient twice daily with sulphur ointment; give five to ten grains of sulphur in a little jam three times a day. Sufficient sulphur was burnt twice daily (on coals on a shovel) to fill the room with the fumes, and of course was thoroughly inhaled by the patient. Under this mode of treatment each case improved immediately, and none were over eight days in making a complete recovery, and I firmly believe in each it was prevented from spreading by the treatment adopted. One case was in a large school.

"Having had a large experience in scarlet fever last year and this, I feel some confidence in my own judgment, and I am of opinion the very mildest cases I ever saw do not do half so well as bad cases do by the sulphur treatment, and, as far as I can judge, sulphur is as near a specific for scarlet fever as possible."

*Transfusion.*—An unexpected opportunity was afforded Dr. ROUSSEL on Saturday last (the 9th inst.) of exhibiting his ingenious apparatus for the transfusion of blood upon a patient in the London Hospital. The case was that of a boy, under the care of Mr. James Adams, suffering from advanced disease of the hip, with evidence of amyloid changes in viscera, and oedema of the affected limb. It was decided to perform amputation at the hip-joint, and ether was administered and Esmarch's bandage applied. The patient, who was extremely prostrate and anæmic, lost no blood during the operation, but the pulse became extremely weak and small. Dr. Roussel happening to be present for the purpose of giving a demonstration of his apparatus to the students of the hospital, it was determined to take advantage of the opportunity thus afforded, and to perform transfusion at once. Accordingly, without continuing the operation after removing the limb and tying the arteries, Mr. Adams supplied six ounces of blood from his own arm to his patient on the table before him. The latter improved notably after the transfusion, the pulse becoming firmer and more full, but the pallor persisted; whilst the surgeon, with his arm bandaged after the venesection, proceeded

on his way with the rest of the operation. We regret to learn that, although the lad rallied from the immediate effects of the operation, he succumbed two days after. —*Lancet*, Dec. 16, 1876.

*Death from Chloroform.*—We learn from the *Medical Times and Gazette* (Dec. 16, 1876), that a death from chloroform took place at Charing-cross Hospital on December 8. The deceased was about to be placed under the influence of the anæsthetic to facilitate the application of the taxis for the reduction of a hernia. Very little chloroform had been given, when suddenly alarming symptoms showed themselves; and although the chloroform was stopped at once and restoratives were applied, death took place immediately.

*A Ready Method of testing Urine for Albumen.*—MR. W. HENRY KESTEVEN recommends (*Med. Times and Gaz.*, Dec. 23, 1876) the following method. Take a piece of thin glass, such as is ordinarily used for microscopical covers; about one inch square is the best size. On the surface of this, slightly to one side of the centre, place about two drops of the urine to be tested; on the other side of the centre place one drop of nitric acid. By gently inclining the glass the two fluids will mix, and any precipitate that is formed will be readily seen when the acid-fumes have passed off. The precipitate may be rendered more apparent by covering the reverse side of the glass with Brunswick black or some other such pigment. Another method of using the thin glass cover is one which will be found particularly handy for use at the bedside. The urine should be placed on the cover as above, and then, with an ordinary pair of dresser's forceps, the slip of glass should be held over the flame of a candle. By so doing the albumen, if present, will be precipitated, and rendered plainly visible by the blackening of the glass with the smoke of the candle. This last method should be practised with care, as, if the glass is held too close to the flame, violent ebullition of the urine takes place, with rapid evaporation. The value of the use of these thin glass covers for this

purpose consists mainly in the ready way in which the urine can be tested by means of them. It is very easy to carry a few of them in the pocket-case for use by those who prefer the warm method of testing; whilst for those who prefer to test the urine cold with the acid, a box could easily be contrived which would carry one or two blackened covers and some nitric acid.

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*Colour-blindness and Railway Service.*—

We are glad to learn, on the authority of Mr. Mason (*Lancet*, Jan. 6, 1877), that so much care is taken on most of the British railway lines to test the vision of the servants of the company. The testing itself is, however, or rather should be, a scientific affair. It cannot be hastily settled by showing a man a few pieces of paper and asking him to name the colours. Even in the healthy eye the extreme lateral parts are incapable of perceiving red. Objects of that colour, which are carried to a little within the verge of vision, suddenly become black, whilst they resume their red tint on being brought forward again, which is not the case with blue or green objects, and it is possible that the red-perceiving elements of the retina may have areas of distribution of different magnitude in different instances. The examination should be made with coloured glasses, and with the aid of a perimeter. We can hardly agree with Mr. Mason in considering cases of downright ignorance of the names of cardinal colours to be more numerous than those of Daltonism. He states that he found "a man, represented as colour-blind, called 'red' yellow, and 'green' red, quite able to appreciate them and small differences in shade of each of these colours, and who quickly became colour perfect by the same process as a school-boy learns the alphabet." We should have passed such a man as (in this respect) a trustworthy railway porter only after repeated trials, if at all. His new knowledge might have failed him at a critical moment, and he would certainly have been long in a state of confusion. The fact that different shades of the same

colour can be distinguished is by no means uncommon, even in cases of well-marked Daltonism. In a recent work of some authority, Bernstein on the "Five Senses of Man," we observe that colour-blindness is stated to occur nearly in the proportion of one in twenty of the population. If this is based on good authority, it must be far more frequent in some nations and localities than in others; for, even granting that it is frequently passed by unnoticed at ophthalmic hospitals, or that the subjects of it rarely apply for relief, it certainly does not exist in anything like that proportion in England. Mr. Haynes Walton calls attention to the fact, otherwise well known, that colour-blindness may be acquired. An impairment of the power of distinguishing shades of colour is not uncommon in cases of amblyopia, from whatever cause this may arise; and, as Mr. Walton suggests, it would be well that periodical examinations of the capacity of officials in regard to perception of colour, on which so much of the safety of the public depends, should be made.

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*Medical Society of London.*—At a meeting of this venerable society held on the 6th of November last, it was unanimously resolved by the society "to exclude persons of the female sex from either becoming fellows of the society or from being introduced to it as visitors."

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*Professor Valentin's Jubilee.*—Professor VALENTIN, of Berne, the discoverer of ganglion cells and ciliated epithelium, celebrated the fortieth anniversary of his academical career on November 6, and was presented by the Medical Faculty with a congratulatory address and a bronze statue of himself. The Philosophical Faculty also gave him a doctor's degree *honoris causa*.—*Med. Times and Gaz.*, Dec. 16, 1870.

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*OBITUARY RECORD.*—The celebrated naturalist, VON BAER, whose name is closely connected with the study of embryology, died on November 28, at the age of eighty-five.

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It will be seen from this that the scope of this work is not dissimilar to the well-known "Principles of Medicine," by Dr. J. C. B. Williams, now long out of print, which in its day met with such unusual acceptance. More practical in its character, however, it seeks to bring to the aid and elucidation of positive therapeutics, the vast accumulation of scientific facts and theories made by the present generation, pointing out the measures to be adopted at the bedside, and establishing them on firm rational grounds. Such a work, by a first-rate man, and fully up to the advanced condition of science, cannot fail to prove of the utmost service to both student and practitioner.

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sical work. Could Sir Astley Cooper rise from his grave and see the changes in half a century of progress, he would find few more worthy sons to take pride in than this shrewd and intelligent American surgeon.—*Brit. and For. Med. Chir. Rev.*, Jan. 1877.

**HENRY C. LEA—Philadelphia.**